

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Macrina Castillo (ARCH/E-ARCH)	CHAPTER 100.1
Address: 1789 Piikea Street Honolulu, Hawaii 96818	Inspection Date: May 9, 2019 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u></p> <ul style="list-style-type: none"> • Resident #1 – No positive tuberculosis history (positive skin test and negative chest x-ray) available for review. • SCG #1 – No positive tuberculosis history (positive skin test) available for review. • SCG #2 - No positive tuberculosis history (negative chest x-ray) available for review. 	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____